DEPARTMENT OF HEALTH
AND HOSPITALS

**HEALTH STANDARDS SECTION**

**Office of Civil Rights Forms**

# Instructions

Required Office of Civil Rights (OCR) forms must be completed and submitted with each Change of Ownership (CHOW) and/or Initial Provider Certification Packet. These provider completed forms are used by the OCR to process clearance for the facilities undergoing CHOWS and Initial Certification. The role of this agency (Health Standards Section of the Louisiana Department of Health and Hospitals) is limited to collecting and forwarding the civil rights data to Center for Medicare and Medicaid Services (CMS), who will then forward to the OCR. The OCR Civil Rights Information Request For Medicare Certification Form, and the Form HHS-690 Assurance of Compliance are included as a part of the state agency packet. All other information that is required by OCR and that must be submitted is described on the OCR website at:

http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html

Carefully read the information on this website regarding Civil Rights Certification for Medicare Provider Applicants (that is located on the above website) for a complete listing of the documents required for submission by OCR.

Any questions concerning the forms must be directed to the regional HHS Office for Civil Rights **(Phone #214-767-4056).**

Please be aware that completed CHOW or Initial Certification packets will not be forwarded to the CMS for processing until all completed OCR forms have been returned to this agency.



Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

# Civil Rights Information Request For Medicare Certification

*Form Approved: OMB No. 0990-0243*

*Expiration Date: 10/31/2010*

**Instructions: Complete all fields and return this form, with the required documents, to your State Health Department, along with your other Medicare Application Materials.**

## I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address: _____
*Street Number and Name*

_____ - _____
*City or Town* *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: (  )  - _____ TDD: (  )  - _____

FAX: (  )  - _____ E-mail: _____

Type of Facility: _____ Number of employees: _____

Corporate Affiliation: _____ Reason for Application: Circle One
Initial Medicare Certification or Change of Ownership

## II. Documents Required for Submission
**(Additional guidance is available at: (www.hhs.gov/ocr/crclearance.html)**

| | |
|---|---|
| **1.** | **Two signed and completed originals of the form HHS-690, Assurance of Compliance.** |
| **2.** | **Your Nondiscrimination Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see example).** |
| **3.** | **Description of methods used to disseminate your nondiscrimination policies/notices (e.g., describe where you post your Nondiscrimination Policy, and include brochures, postings, ads, etc.).** |
| **4.** | **Facility admissions policy that describes eligibility requirements for your services.** |
| **5.** | **Copies of brochures, pamphlets, etc. with general information about your services.** |
| **6.** | **Procedures to effectively communicate with persons who are limited English proficient (LEP), including (see example):**<br>**a) Process for how you identify individuals who need language assistance;**<br>**b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);**<br>**c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;**<br>**d) Appropriate restrictions on the use of family and friends as LEP interpreters;**<br>**e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc.** |
| **7.** | **Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including (see example):**<br>**a) Process to identify individuals who need sign language interpreters or other assistive services;**<br>**b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);**<br>**c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System;**<br>**d) A list of available auxiliary aids and services;**<br>**e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served;**<br>**f) Appropriate restrictions on the use of family and friends as sign language interpreters.** |

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

**Civil Rights Information Request**
**For Medicare Certification**

*Form Approved: OMB No. 0990-0243*

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| | |
|---|---|
| **8.** | **Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see example).** |
| **9.** | **For healthcare providers with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.** |
| **10.** | **For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances (see example).** |
| **11.** | **A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted.** |

**III. Certification**

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

| Name and Title of Authorized Official | Signature | Date |
|---|---|---|
| | | |

# ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

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_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97